

Date:	Last Name	First Name	AHCCCS ID#:	Age:
Primary Care Provider Name and Office Phone Number			Contractor:	DOB:
Accompanied by:			Allergies:	
Birth Wt:	Weight:	Percentile:	Length:	Percentile:
Head Circ:		Percentile:		

HISTORY:

Temp:	
Pulse:	
Resp:	

Parental Comments/Concerns:
Nutritional Screen: Breast Feeding: _____ Formula (type): _____ Supplements: _____

Developmental Screen: Age Appropriate? (e.g., babbles & coos, rolls front to back, controls head well) Yes ____ No ____

If suspicious, specific objective testing performed _____

Behavioral Screen: Age appropriate? (parental interview) Yes ____ No ____
PHYSICAL EXAM

Are the following normal?	Yes	No	Describe abnormal findings:
1. Skin/Hair/Nails			
2. Ear/Hearing			
3. Eyes/Vision (red reflex)			
4. Mouth/Throat/Teeth			
5. Nose/Head/Neck			
6. Heart			
7. Lungs			
8. Abdomen			
9. Genitourinary			
10. Extremities			
11. Spine (scoliosis)			
12. Neurological			
13. Hemoglobin/Hematocrit (perform at 1-9 mos of age)			

ASSESSMENT & PLAN:

IMMUNIZATIONS:	Pt. needs immunizations?	Yes ____	No ____	Delayed? ____	Deferred? ____
Given today? Hep B ____	DTaP ____ Hib ____	IPV ____	PCV ____	Other ____	

ANTICIPATORY GUIDANCE

- | | | |
|---|--|---|
| <ul style="list-style-type: none"> ▪ Supine sleep position ▪ Car Seat ▪ Injury prevention/rolling ▪ Emergency/911 | <ul style="list-style-type: none"> ▪ Drowning prevention ▪ Passive smoke ▪ Teething/choking/solid foods ▪ Dental gum care/bacteria | <ul style="list-style-type: none"> ▪ Postpartum Adjustment ▪ Parenting Practices ▪ Family involvement ▪ Infant bonding ▪ Next appt./transportation needed? |
|---|--|---|

REFERRALS: CRS ____ WIC ____ DDD ____ ALTCS ____ Specialty ____ Other ____

Clinician Name (print): _____	Clinician Signature: _____	Yes ____ No ____ See Additional/Supervisory Note?
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